Autumn 2015

# SUMMONS

AN MDDUS PUBLICATION FOR MEMBERS

• Moral of the tail • Letter from the GMC • Making prevention pay •

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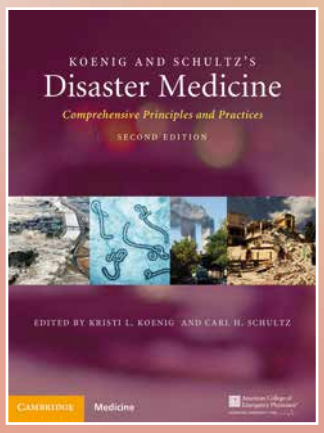


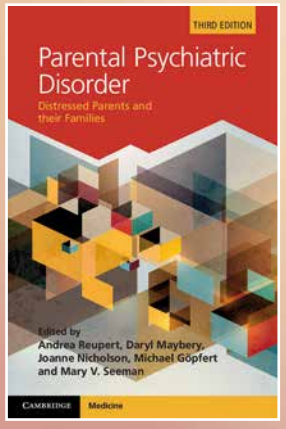


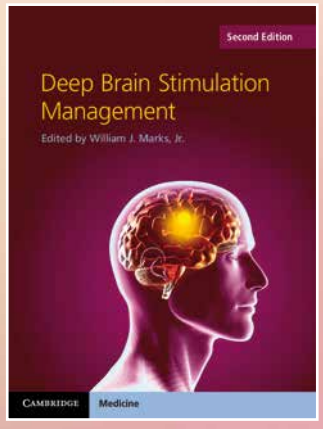


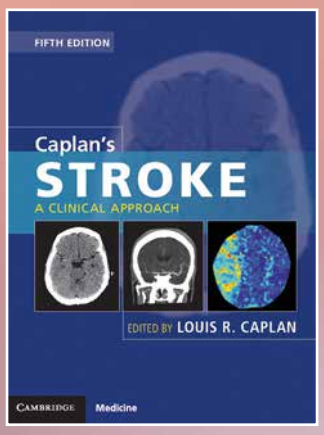


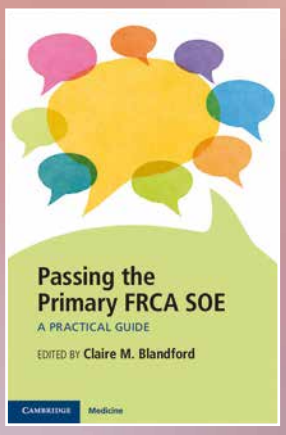


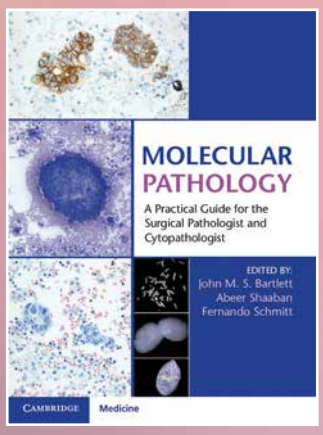


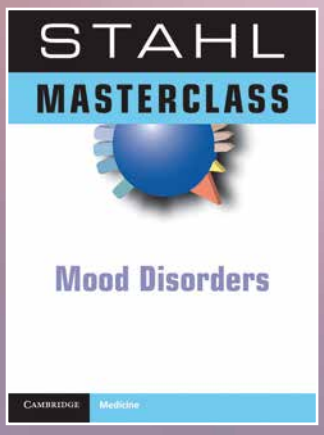


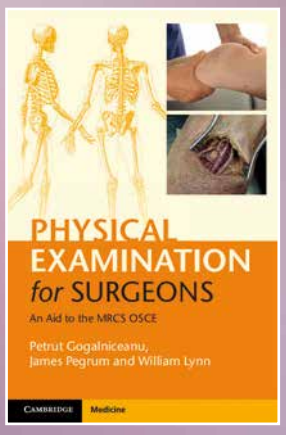


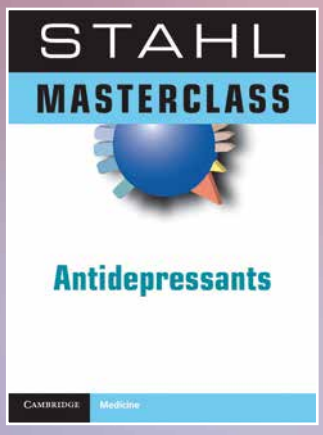


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## FROM THE EDITOR

THE transformation in dental health in the UK over the past 50 years is a remarkable success story. Advances in preventative and restorative dentistry, health promotion and better nutrition have all played their part, but the improvements have not been achieved evenly across society and this remains a concern.

The Childsmile initiative in Scotland, focusing on prevention and early intervention, has produced encouraging results and reason for optimism. On page 18 of this issue of *Summons*, Dr Colwyn Jones describes the approach that has been adopted and results to date.

The proposed new NHS dental contract in England also changes the focus from treatment to prevention. Professor Jimmy Steele led the 2009 review of NHS dental services in England and in our Q&A on page 10 he provides a personal perspective on the progress made during the pilot phase of the new contract.

Our clinical risk article (page 16) focuses on cauda equina syndrome, a condition that continues to result in claims for clinical negligence, often of high value in view of the severe and long-term consequences for patients. Robert McFarlane's update offers helpful guidance on diagnosis and management of this uncommon but important condition, and there is also a case study on the same topic (page 21).

In the course of assisting our members with GMC complaints, it is clear that these can be extremely stressful. Only a minority, however, will progress to any form of sanction, as highlighted in the most recent GMC fitness to practise statistics in 2014. On page 12, Mary Peddie describes how at MDDUS we approach GMC complaint handling, and she offers practical guidance on dealing with them when they arise.

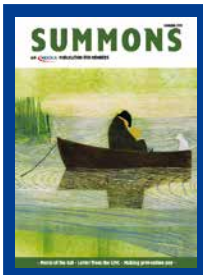
**Dr Barry Parker**





### REGULARS






Cover image:
**'Stillness'** (detail)
**Pauline Jacobsen.**
Woodcut, 1992.

Pauline Jacobsen studied at Ealing Technical College & School of Art (1949). She lived most of her life in Scotland and had five children. Her wood engravings are known for her use of the natural grain in the wood which she used to beautiful effect to make her prints, which often have a spiritual theme.

Art in Healthcare (formerly Paintings in Hospitals Scotland) works with hospitals and healthcare communities across Scotland to encourage patients, visitors and staff to enjoy and engage with the visual arts. For more information visit www.artinhealthcare.org.uk Scottish Charity No SC 036222.


**Editor:**
Dr Barry Parker
**Managing editor:**
Jim Killgore
**Associate editor:**
Joanne Curran
**Editorial departments:**
MEDICAL Dr Richard Brittain
DENTAL Mr Aubrey Craig
LEGAL Simon Dinnick

Please address correspondence to:

**Summons Editor**
MDDUS
Mackintosh House
120 Blythswood Street
Glasgow G2 4EA

jkillgore@mddus.com

**Design and production:**
Connect Communications
0131 561 0020
CONNECT
*Innovation in communication*

**Printing and distribution:**
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The MDDUS is not an insurance company. All the benefits of membership of MDDUS are discretionary as set out in the Articles of Association.

## Ensure you are adequately covered

IN August of this year, new healthcare legislation came into effect giving the GMC powers to check whether doctors have appropriate insurance or indemnity. These changes build on the existing duty set out in *Good Medical Practice* stipulating that doctors must have adequate cover in place to prevent patients being disadvantaged if they need to make a medical negligence claim about clinical care or treatment.

The GMC is now able to check the insurance/indemnity status of any doctor practising in the UK. Doctors without proof of appropriate insurance or indemnity may be refused a licence to practise or have an existing licence removed. The type and level of insurance or indemnity required depends on where a doctor works, whether they are employed or self-employed and the type of work they do.

Now may be a good time to review your MDDUS membership to ensure it reflects your current practice.

MDDUS is a mutual indemnity organisation and at the heart of mutuality is a commitment among members to contribute an appropriate amount to a common fund held on behalf of all members. Your annual subscription is calculated according to the associated risks undertaken in your particular practice of medicine. We carry out checks of gross private practice earnings from time to time to ensure that members are complying.

Your renewal notice will show the level of earnings upon which your subscription has been based and it is your responsibility to ensure that this is sufficient to cover expected earnings for the year to come. Members whose subscriptions are based on the number of sessions worked per week, such as GPs, must ensure adequate indemnity is in place to cover all clinical commitments, including work outside standard NHS sessions, such as private GP work, out-of-hours sessions, treatment at sporting events for players and athletes, and forensic police physician and occupational health work.

Should any change be required, inform MDDUS immediately so that a revised subscription for next year can be calculated. If at the end of next year your estimate has proved to be too high or too low you will have an opportunity at that time to adjust it.

We would like to be clear that the figure used should be your gross private earnings from the practice of medicine, however delivered. In the event that you have formed a company for accounting or other purposes, the relevant figure is the gross income to that company in relation to your practice of medicine. In our recent experience, there are still a small number of doctors declaring their salary from their company as opposed to the gross income. In such circumstances we have discretion to make adjustments retrospectively to ensure adequate and appropriate indemnity is in place.

If you have any questions please telephone our Membership Department on 0845 270 2038.

## Dental complaints handling – interactive module

MDDUS members can now enhance their knowledge of dental complaints handling with a new interactive module from our Risk Management team.

Aimed at dentists and practice managers, the module is CPD-verified and offers a wide range of information and advice on best practice in complaints handling. The module takes around 45 minutes to complete and covers a range of topics including:

- the common reasons patients complain
- the requirements in relation to handling complaints professional guidance on acting on patient concerns
- how you can review your own practice processes, roles and responsibilities in relation to complaints
- how you might investigate and respond effectively
- strategies to minimise complaints in dental practice.

Members can login using their surname and MDDUS membership number. Access on the Interactive modules page of the eLearning section in Risk Management at **mddus.com**

## Audit reminder for Scottish dentists

A NUMBER of key clinical audit deadlines are approaching for primary care dentists in Scotland. A reminder has been sent out by NHS Education for Scotland (NES) to practitioners across the country highlighting the end of the three-year audit cycle on July 31, 2016.

Those who were already on the dental list on August 1, 2013 must undertake 15 hours of approved and certified clinical audit activity within the cycle. This includes vocational dental practitioners who started VT on August 1, 2013 and became associates in August 2014.

New audit applications must be submitted to NES by December 18, 2015 "at the very latest" to allow them to issue approval by the end of January. All projects must be completed within six months of the approval date.

NES has made improvements to the clinical audit area of their website and enhanced the dental audit section of their Portal site to help dentists with the audit process.

There are now step-by-step instructions to assist those planning an audit project, undertaking a pre-approved audit or submitting a significant event analysis (SEA) report, plus information on peer

## IN BRIEF

**NEW MDDUS RISK VIDEOS** Two new video presentations are now available for members to watch online. The first covers the risks involved in engaging with social media as an individual doctor and as a practice team. The second summarises the main principles which apply to all aspects of medico-legal cases, including negligence claims, complaints, GMC investigations and inquiries into death. Access them from the eLearning page in the Risk Management section at **mddus.com**. Use your surname and membership number to login.

**RISK FACTOR VIDEO: NHS ENGLAND PERFORMERS LIST** Risk adviser Alan Frame is joined by MDDUS solicitor Susan Trigg to discuss the scope, remit and impact of NHS England investigations under the Performers List Regulations 2013, focusing on complaints about practitioners and other common medico-legal risk areas. Access


## Nominations open for eighth annual BMJ Awards

NOMINATIONS are now invited for The BMJ Awards 2016 – once again with headline sponsorship from MDDUS.

Now in their eighth year, the awards are firmly established in the annual medical calendar. Entrants can fill in a nomination form on the awards website and judging will take place in advance of a gala ceremony at the Park Plaza Hotel on Westminster Bridge Road, London, on 5 May, when the winners will be announced.

This year will see the introduction of patients in the judging process – with each panel including at least one patient in keeping with The BMJ's Patient Partnership initiative launched last year. New categories this year will include Cancer Care Team of the year and Prevention Team of the year.

*BMJ* editor in chief, Fiona Godlee, said, "Every year we are amazed at the quality and breadth of the entries we receive. They reflect the professionalism, commitment, creativity and hard work that characterise so much of the day-to-day provision of healthcare in the UK. In these tough and turbulent times for the NHS it has never been more important to showcase the best of British medicine."

"We hope the BMJ Awards will reward excellence, encourage learning and inspire innovation at all levels in the health service."

review and practice-based research as forms of audit. Dentists can also view the status of their NES-approved and certified audit activity via Portal. (Audits approved by health boards will not be listed.) A total of eight pre-approved audits are still available for dentists to join via the Portal site's "Dental Audit" tab within the iBooklet section. These will remain on the site until January 31, 2016.

The audit requirements vary for dentists who joined the list for the first time after August 1, 2013. More information can be found on the NES website but dentists with specific questions are being advised to contact their health board for further information.

## Doctors should extend 'sunshine rule' to include patient gifts

Doctors are urged to exercise caution when offered gifts from patients or pharmaceutical companies.

The government recently announced the introduction of the "sunshine rule", meaning that doctors and other NHS staff will have to declare gifts, payments or hospitality received from pharmaceutical companies. From next year it will be mandatory for NHS staff to keep a register of hospitality and gifts. Any member of staff who fails to declare such information will face sanctions and disciplinary action under the Bribery Act 2010.

MDDUS medical adviser Dr Naeem Nazem believes transparency and caution are also required when it comes to accepting gifts from patients.

"The new government measures are in relation to gifts from pharmaceutical representatives and medical device makers. However, we would urge all doctors to adopt the spirit of the legislation and also keep a register of gifts from patients," says Dr Nazem.

"In the interests of being open and honest and to avoid any perception of bias, all practices should already have a policy on accepting gifts. As part of that policy, there should be a gift register which can be made available to the clinical commissioning group (or health board in Scotland) at their request."

the video in the Risk Management section at **mddus.com**.

- **NHS SCOTLAND SCHEME TO REDUCE DENTAL COSTS** A new initiative run by NHS Scotland aims to reduce costs for practices. Up to 400 practices will be able to sign up to the DenPro collaborative procurement scheme ahead of its launch in January 2016. Practices who join the scheme will be given access to an ordering system offering general dental consumables such as instruments, impression materials and cements at a reduced price. Look out for more details on the NHS National Services Scotland website.
- **MDDUS STUDENT FACEBOOK COMPETITION** Calling all medical and dental students – "like" our MDDUS Student Facebook page and you will be entered into our FREE prize draw to win £50 of iTunes vouchers. You can find our page at **www.facebook.com/mddus.student** or search Facebook for 'mddus student'.

## Mandatory FGM reporting

DOCTORS and dentists in England and Wales are now required to report cases of female genital mutilation (FGM) in girls under age 18.

This new "mandatory duty" (introduced in the Serious Crime Act 2015) means that from 31 October, regulated health and social care professionals and teachers in England and Wales must report "visually confirmed or verbally disclosed" cases of FGM in girls under 18 to the police.

The Home Office has published guidance which sets out the legal requirements (**https//tiny.url.com/ocjsvda**) and the process to follow for making reports. It also details what action may be taken for failure to comply with the duty.

A range of resources (**http://tinyurl.com/na64h4p**) are also available to help ensure that healthcare staff are equipped and confident to deal with cases of FGM. These include quick guidance for professionals, a poster for NHS organisations to publicise the duty to their staff, training slides and a leaflet for staff to give to patients to explain the new duty.

Minister for Preventing Abuse and Exploitation Karen Bradley said: "The duty is an important step forward in tackling this practice, and we believe that it will make sure professionals have the confidence to confront FGM.

"There is clear evidence that existing systems are not yielding appropriate referrals to the police. We need to ensure that where a serious crime has been committed, the police are informed and can instigate an appropriate multi-agency response to protect girls and bring perpetrators to justice."

## Prescribing errors in primary care

A *BMJ* study of nearly one million UK patients has found that around one in 20 triggered indicators for unsafe prescribing in general practice and over double that number triggered indicators for inadequate monitoring.

Researchers from the University of Manchester studied the health records of 949,552 adult patients in 526 general practices who were potentially at risk of prescribing or monitoring errors. They focused on prescriptions of anticoagulants, anti-platelets, NSAIDs, beta-blockers, glitazones, metformin, digoxin, antipsychotics, combined hormonal contraceptives and oestrogens. The study also considered potentially inadequate monitoring by blood test of patients with repeat prescriptions of angiotensin converting enzyme inhibitors and loop diuretics, amiodarone, methotrexate, lithium or warfarin.

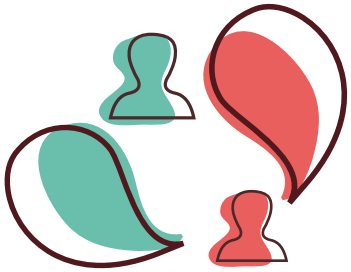
They found that 5.26 per cent of patients triggered at least one prescribing indicator and 11.8 per cent triggered at least one monitoring indicator. The prevalence of different types of potentially hazardous prescribing ranged from almost zero to 10.2 per cent, and for inadequate monitoring the range was 10.4 to 41.9 per cent.

Older patients and those prescribed multiple repeat medications had significantly higher risks of triggering a prescribing indicator, whereas younger patients with fewer repeat prescriptions had a significantly higher risk of triggering a monitoring indicator. High variation was found between practices for some indicators.

The researchers make the point that safety indicators show prescribing patterns that can increase the risk of harm to the patient and should generally be avoided but there will "always be exceptions where the indicator is clinically justified".

Other studies have found that adverse drug events account for around seven per cent of hospital admissions in the UK with half of these judged to be preventable. A 2012 study found that one in 20 prescription items was associated with a clinically important error and one in 550 was associated with a serious error.

## Consultation on language checks for dentists



A CONSULTATION has been launched on a draft policy to introduce English language checks for dentists who want to work in the UK.

The government unveiled plans late last year to extend language testing to include clinicians from EU countries. Previous laws only allowed checks on those from outside the European Economic Area (EEA).

The new powers mean the General Dental Council can now ask for evidence of a dental professional's language skills prior to registration. It can do this if there are concerns that the dentist does not have sufficient knowledge of English.

Would-be registrants who are unable to provide evidence of their abilities will be asked to take an English language test.

The GDC has launched a consultation to gather views on the type of information that will be accepted as evidence of language skills and whether the guidelines should be applied to all applicants, including those who have trained and qualified from within the EEA and those who have trained outside the EEA.

It is thought the new powers will come into effect in March 2016. They must be enforced "proportionately" and so will apply to all dental professionals wishing to

### IN BRIEF

● **LONDON TB RATES** Some London boroughs have tuberculosis rates as high as 113 per 100,000, topping levels in countries such as Rwanda, Iraq and Guatemala. These figures are published in a new report by the London Assembly Health Committee which also found significant ignorance on how TB is spread and disease symptoms. It calls for better public information and more outreach work in the city. Access at **http://goo.gl/UN1aww**

● **NEW ORAL CANCER TOOLKIT** AN online toolkit designed to help dentists and GPs spot the signs of oral cancer has been launched by Cancer Research UK. The launch coincides with new statistics that show oral cancer is now the tenth most common cancer in men and fifteenth most common in women. Access at **http://goo.gl/oEuQf4**

● **PROPHYLAXIS FOR INFECTIVE ENDOCARDITIS** Antibiotics should not routinely be prescribed to prevent infective

register or restore their registration with the GDC.

The government's consultation document published last year offered reassurance to UK clinicians, stating: "For graduates of UK universities, the fact that the registrar will be able to rely on the information supplied by applicants with their registration application should mean that a registrar should be able to be satisfied about the English language ability of UK-qualified applicants with no additional procedural burden."

The GDC consultation closes January 4, 2016 and can be accessed at **www.gdc-uk.org**

## More urgent referrals linked to lower cancer mortality

GP PRACTICES with a low propensity to use urgent two-week referral pathways for patients with suspected cancer had higher mortality rates for the disease according to a study published in the *BMJ*.

A research team lead by Professor Henrik Møller of King's College London looked at the clinical records of 215,284 patients with cancer who were diagnosed or first treated in England in 2009 and then followed up to 2013. In that period 91,620 deaths occurred – 51,606 (56 per cent) within the first year after diagnosis.

Among key findings, a subgroup of 37 per cent of cancer patients registered with general practices with a low propensity to use urgent referral was identified, and these patients showed a seven per cent increased mortality rate compared with those from practices with higher rates of urgent referral. The association between use of the urgent referral pathway and mortality was consistent for the main types of cancer apart from breast cancer.

The researchers concluded that: "For practices that have a consistently low propensity to use the urgent referral pathway (for example, on measures and in consecutive years), the data suggests that an increased use could plausibly lead to lower mortality and higher survival of patients with cancer."

## Dental practices confused over data protection

CONFUSION exists over when a dentist is required to register with the Information Commissioner's Office (ICO) in compliance with the Data Protection Act, according to a recent report.

The ICO visited 21 dental practices across the UK and conducted an online survey in order to understand the information risks and challenges that dentists face. It found there was confusion over data protection requirements, with some dentists registering with the ICO when it is not necessary and others not registering as required.

The report (https://goo.gl/SieQq8) also found that dentists do not always have written contracts with external suppliers containing appropriate clauses about information security, particularly with contractors supplying IT services to the practice. The ICO also discovered that some practices utilising new technologies, such as mobile and personal devices, were not appropriately controlling associated risks.

There was a lack of clarity in some practices over retention policies (to determine when records, both physical and electronic, should be destroyed). Retention periods were not always clear and not generally applied to electronic records.

Investigators found that overall dentists are "not always engaged with sources of best practice and new guidance in relation to information governance".

The report states: "Dentists operate within a number of different complex structures, including individual practices, partnerships, expense-sharing arrangements, limited liability companies and dental corporates. This has led to some confusion about the circumstances in which a dentist is (or is not) a data controller, responsible under the DPA for patient data, and also for registration with the ICO."

It encourages practices to visit the ICO website (www.ico.org.uk) where there is a self-assessment tool and also specific dental practitioner FAQs.

endocarditis in cardiac patients undergoing dental and certain other interventional procedures, NICE has reaffirmed in updated guidance. Clinicians had questioned the advice first set out in a 2008 guideline. NICE assessed latest research and carried out a review of its guideline and found "insufficient evidence" to warrant a change. It is recommending further research. **www.nice.org.uk/guidance/cg64**

● **QUARTER OF GP VISITS**

**AVOIDABLE** A new report has found that over 27 per cent of GP appointments could potentially be avoided if there was more coordinated working between GPs and hospitals, greater utilisation of primary care staff, more effective use of technology to streamline administrative burdens and wider system changes. The NHS Alliance and the Primary Care Foundation argue that the reduction of bureaucracy in general practice should be made a national priority.

# A TAILORED PROCESS OF CONSENT

*Cherryl Adams*


**CONSENT** has been in the spotlight in the last few months with the recent ruling on *Montgomery v Lanarkshire Health Board (Scotland) [2015]* and the ongoing implications for medical practice. In basic terms, the *Montgomery* ruling reaffirmed that the consent process must be patient-specific and tailored to the needs of each individual.

Demonstrating informed consent in a legal context is often difficult in hospital claims and recent analysis among our private medical cases at MDDUS has highlighted common failures across the consenting process.

## Risks and benefits

By far, the highest percentage of hospital claims in our analysis involved surgical treatments where patients perceived that something had "gone wrong". These ranged from a complete failure of the procedure to unsatisfactory outcomes in appearance or with rehabilitation. Common findings included failure to adequately manage patient expectations, insufficient clarity around patient needs and a lack of contemporaneous records.

Looking more specifically at the consent process, cases often involved a failure to effectively communicate the risks and benefits of procedures and a lack of discussion on the range of alternatives and other potential outcomes. Documentation and record-keeping of patient discussions were often found to be inadequate – and a failure to evidence this practice was a common legal challenge to the assumption of consent.

## An MDDUS case

One MDDUS case which helps illustrate this involved a patient who was admitted as a day case for diagnostic colonoscopy. Consent was obtained via a signed patient consent form detailing the procedure and what it involved but not the associated risks or benefits. A separate information sheet was also provided to the patient but this was not attached to the consent form. The surgeon discussed the procedure with the patient following admission and prior to the operation but the details of this discussion were not recorded in the patient record.

One particular feature of note in this case was a timeframe of less than one hour between admission and the patient being taken to theatre. In that period the patient was admitted, gowned, briefed on the procedure and spoken to by the surgeon before a consent form was signed.

During the actual procedure, the patient sustained a bowel perforation which was further complicated by the development of peritonitis. The patient subsequently raised a claim citing breached duty of care, alleging that our member had failed to obtain valid consent.

Investigation revealed a number of vulnerabilities in the case. Questions were raised around what information was specifically shared and discussed with the patient and there was concern over the timing and documentation of consent.

In particular, there were vulnerabilities in regard to GMC *Consent* guidance as set out in paragraphs:

**5b** "...The doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option..."

**18d** "...give the patient time to reflect, before and after they make a decision, especially if the information is complex or what you are proposing involves significant risks".

Due to these vulnerabilities a decision was taken, with our member, to settle the case without admission of liability.

Some points for consideration in regard to this case include:

- Where possible, the consent process and discussions should commence before a patient is admitted to hospital for the procedure.
- Ensure the information you present is clear and accurate and phrased in a way patients can understand and which encourages questions and feedback.
- Don't make assumptions about what is and is not important to individuals. Patients may have a different perspective and other priorities.
- Don't assume that the patient will read or understand documentation provided on the day of a proposed procedure. Emotion and anxiety may affect their ability to comprehend crucial information.
- Don't assume that the patient will retain the information discussed on the day, and especially immediately prior to the procedure.
- If you delegate the consent process to someone else, ensure that they are suitably trained and qualified, have sufficient knowledge of the procedure and a clear understanding of the risks involved.
- To evidence your practice, fully document discussions that have taken place, including patient feedback, concerns and comments, and how these have been addressed; aim to have, and demonstrate, a dialogue rather than a monologue.

## Write it down

The consent process is heavily reliant on clear, unambiguous and two-way communication. Face-to-face communication where the patient is encouraged to share concerns, observations or preferences and has time to reflect is vitally important.

Our experience shows that when things go wrong, defending such cases can be heavily reliant on written material, and that is purely and simply effective and contemporaneous record-keeping and documentation of relevant discussions and actions – including consent.

■ ***Cherryl Adams is a risk adviser at MDDUS***

# THE MORAL OF THE TAIL

*Deborah Bowman*

**I HAVE** spent more time than I would have wished in my local veterinary surgery over the last eight weeks.

Fat cat and neurotic thin cat have developed a range of injuries, symptoms and signs that would, between them, make a decent OSCE circuit in membership examinations. This time at the vets has led me to reflect on its ethical culture compared with healthcare professions. As I have sat shielding neurotic thin cat from the feisty British bulldog in the waiting room and trying to stop fat cat from battering his way out of his carrier to get to the parrot opposite, I have reflected on and learned much from the comparisons.

Compassion is everything. It is a uniquely powerful tool in any clinical setting. Compassion, when it is evident in everyone within a practice or team, instils confidence and trust. Everyone we met was kind to the creatures, both with and without fur. In common with most, if not all, medical and dental practices, the phones rang constantly, people presented in varying states of heightened emotion, patients were frightened and often in pain, yet the calm and gentle way in which every person responded was immeasurably therapeutic.

Showing compassion is the simplest and yet also the most demanding requirement in healthcare. "Simple" because it does not depend on complex knowledge or advanced technical skills; "demanding" because being consistently kind, responsive and engaged with people when you're exhausted, overwhelmed or simply stressed are constant challenges.

Familiar concepts such as confidentiality and consent are different beasts when applied to, well, beasts. Confidentiality did not seem to be a consideration for either the staff or patients in the veterinary surgery. Conversations between clinicians and owners took place in the reception area. I learned more about hernias in dogs, continence in rabbits and pancreatitis in cats than I ever expected to from waiting for an appointment. I knew the patients' names (often highly entertaining and sometimes inexplicable: a guinea pig named "Alan" anyone?), addresses and symptoms simply from sitting in the waiting room. I watched as drugs were explained in front of a two and four-legged audience and administration techniques were demonstrated before men, women and their best friends left the building.

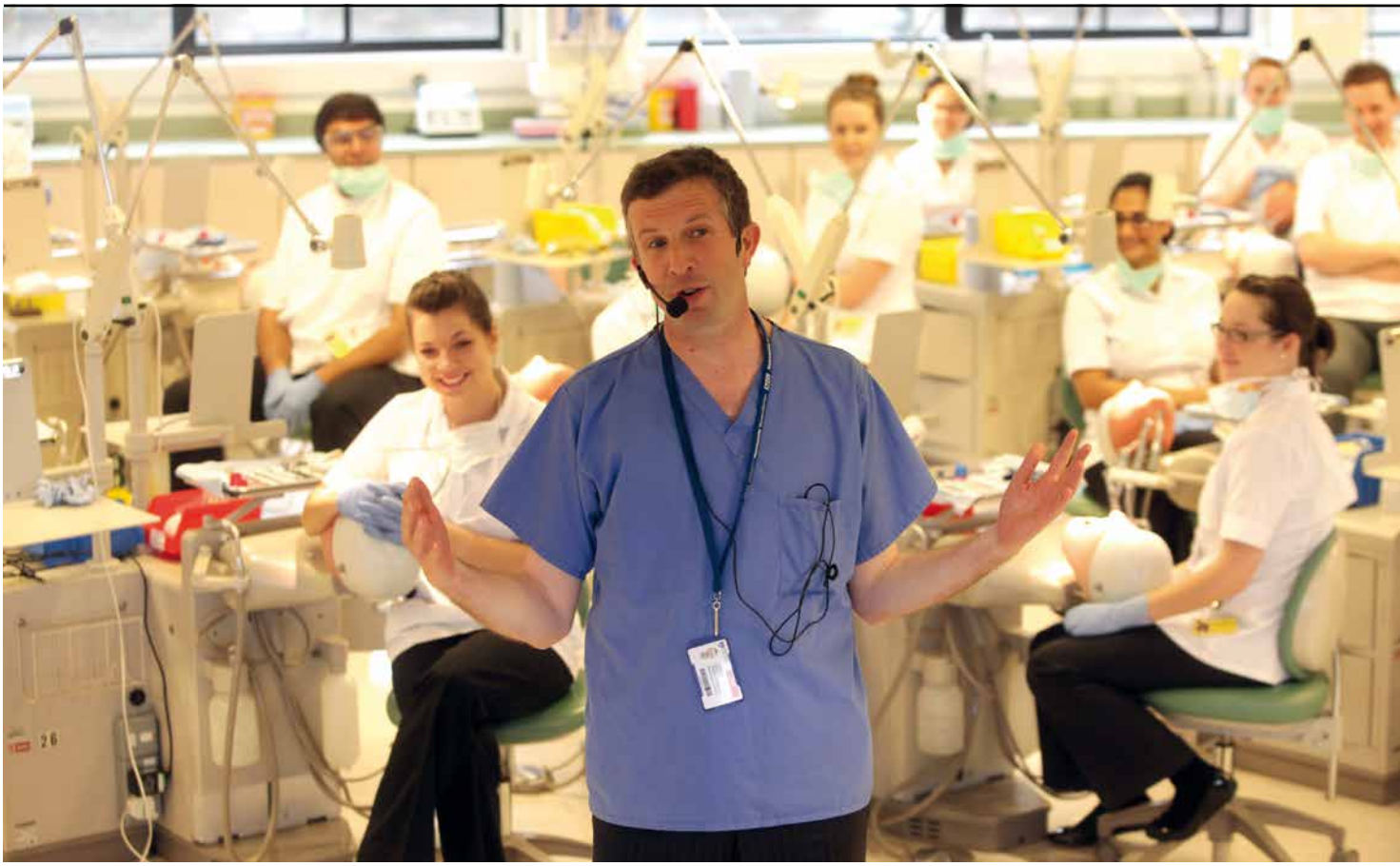
Consent was negotiated with great care and attention, albeit with a proxy rather than the patient. Indeed, I bear the scars of fat cat's and thin neurotic cat's forceful expression of their refusal of treatment. Nonetheless, George the vet proceeded to examine, inject, swab, debride and dress their respective wounds. I was given detailed explanations of the rationale for every intervention and the options available for treatment. I was invited to choose between types of antibiotics – the third-generation and long-acting injection or the traditional oral version. Looking at my own scars, I made my choice based less on feline best interests and more in my own best interests wishing to avoid further injury as I flailed around trying to administer tablets to the patients in question.

The balance of individual and third-party interests was considered in other ways too. The antibiotic conversation included a discussion about resistance and the suggestion to swab was as much to vitiate the risks and impact on antibiotic effectiveness as it was to ensure that neurotic thin cat and fat cat received the most appropriate treatment. Public and wider community interests also informed a discussion about the need to keep an infectious fat cat inside for 7-10 days given the disastrous combination of his brute size, stupidity, greed in stealing other animals' food and propensity to fight with any creature that crosses his path. It was, explained George, an ethical imperative to lock that cat flap.

Of course, the elephant in the room (not literally – this is Wimbledon not Regents Park) is money. Every item comes with a price tag. Of course, that is the case in the NHS too, but the difference is that patients need not bear the cost of whatever advice or treatment they are offered. At each turn I am given details of the price of each examination, test, investigation and procedure. And as the figures turn into an ever larger and more frightening total at the bottom of the page, I am calculating whether my current account can take the hit or whether I need to wield the credit card. I am also silently giving thanks for the long-held pet insurance that means that eventually I will receive most, albeit not all, of this money back.

I am fortunate to be able to afford insurance in the first place and not to have to make impossible choices because of cost. Many will not be. I leave grateful for vets and their exemplary staff, but also more grateful than ever for the NHS.

■ ***Deborah Bowman is Professor of Bioethics, Clinical Ethics and Medical Law at St George's, University of London***



# Making prevention pay

*Professor Jimmy Steele discusses the ethos behind the proposed new NHS dental contract in England and progress in the pilot implementation*

PROFESSOR Jimmy Steele is head of the School of Dental Sciences at Newcastle University and a practising consultant in restorative dentistry with Newcastle Upon Tyne Hospitals NHS Foundation Trust. His main research interest is population oral health and oral health services, including policy and economics.

In 2009 he led the Review of NHS Dental Services in England for the Government and since then has been working with the Department of Health to pilot a new NHS dental contract based on the recommendations.

### Why is a new dental contract needed?

Well, there are many reasons and it gets quite complicated but the main one really is that the original NHS contract was set up in 1948 and the dental world is unrecognisably different. Sometimes old things are good but during the intervening (nearly) 70 years oral health right across the UK has been transformed. In 1968, 37 per cent of British adults had complete dentures but by 2009 it was about six per cent, and now it will be even less. Caries which were once universal, whilst now still common, affect the population in a different way. There are hordes of people whose risks are lower, but a minority whose risks are high and are often from a different sector of society from the low-risk people. Periodontal disease is a bigger problem and needs a different strategy of management. The old contract evolved a little but not enough to really meet this need. When a new contract was introduced in England in 2006 it really didn't solve the problem. If we are to use our scarce resources and our improved clinical evidence and knowledge better, we need to structure the payment system to allow that.

### What is the ethos behind the new approach?

The National Health Service is about health, not just about treatment – and dental treatment can be damaging as well as good, of course. The most common dental diseases and conditions are preventable and we will never succeed in treating them away. The ethos is to make sure that the drivers in the system are for dentists to look after the health of their patients rather than only chase treatment targets – in other words to find ways to reward better health. Of course, that needs to be balanced against making sure that the people who most need active and complex treatment can get it.

### The NHS dental contract pilots began in 2011. What aspects are working best?

Dentists get the need for prevention, and whether we are talking about dentists who are taking part in the pilots or prototypes or the much larger number still in the old system, there is a general shift towards a different philosophy and the language is often about prevention. For those working in the pilots (and now the prototypes) they

PHOTOGRAPHS: NEWCASTLE UNIVERSITY

seem genuinely to be managing risks rather than chasing UDA (unit of dental activity) targets.

### What are proving to be major challenges?

All change is difficult. It requires a new way of thinking and that is really hard. Some of this is about management within the practice. Where the principals have thought it through and planned and made changes from day one and got buy-in from the practices, then it has worked okay, though of course the change was still a challenge. Where that did not happen and people pretended that nothing needed to be done differently – then there have been bigger problems.

### How have patients responded?

They actually seemed to respond very well. Some data after a couple of years showed a reduction of moderate periodontal disease by about a third because it had been detected and managed appropriately. Patients seem to like having a conversation about their own oral health in a way that has never happened before. The pilots are just a first run-through though, a dress rehearsal and like any dress rehearsal, a lot has been learned. As we move through prototypes it should be tighter but there is yet more learning required.

### Is there any one model of dental remuneration emerging as most effective?

Every variation has been revealing but the move now has been to have a proportion of the contract paid per patient (and if patients are lost to the practice that contract will come down), but that some will pay for aspects of treatment. There are nuances within that but it is too early to tell. My feeling is that it makes sense to set the capitation fee to include caries and periodontal disease management as well as prevention, but to separate out the more complex care into the fee-for-service element because there is a real incentive to get the prevention to work and to think that through. That way you get paid the same but need to do less routine treatment.

### How will the new contract be funded and will additional funding be available?

In a world where there is little more money anywhere near the NHS, no-one will put more money in I'm afraid. If we had done this a decade ago we would have been able to oil the wheels I am sure with a bit of resource; now being realistic that will not be the case. However, it makes people a little more imaginative in finding solutions, so what has now been done is to reduce the treatment targets substantially in the prototypes in order to create time for prevention and to try to ensure that treatments go where they are most needed. This has been a major step-change. It is not new money but a huge shift in emphasis and although it needs a bit of ironing out it is, in my view, very important.

"The National Health Service is about health, not just about treatment"

### How will compliance and quality be ensured?

Ah now, that gets complicated. We will need measures in place that are simple and that show whether a practice is improving health or not. Critical to this is a way of collecting some simple data or indices from all practices with the minimum of effort (for example from some simple data in the IT system). These will need to change from time-to-time but it is important that practices themselves know how they are doing in health outcomes compared to their peers. This is something we have never been very good at, so it is an important part of the process. I have been frustrated that this has not been done as well to date as it should have been because there have been so many things to do that have distracted efforts.

### How did you get involved in reforming dental practice?

Well, it was never intended! I knew all about the population trends in disease which were so dramatic and was happy to comment on that, which led naturally into how we might need to manage services differently. I got asked to lead the review of NHS dentistry in England at the back end of 2008 I think because I had said quite a lot up to that point. It was really challenging but ultimately reasonably well received at the time, so I was asked to continue to have input. What you realise is that recommendations and ideas are easy. Implementation is incredibly complicated. I get a bit frustrated now when people complain about how we should just change this or change that – changing an entire national system is fabulously complex. I think sometimes people think that I make the decisions, but I really do not. Civil servants and their teams on behalf of politicians and the NHS bureaucrats make the decisions. Maintaining continuity across two elections has been a particular challenge.

### What do you do with the rest of your time (little of it there no doubt is)?

Well, I used to be a very good birder (I found the UK's second ever black-faced bunting in a hedge near the sea in Northumberland and lots of other interesting things) but am not as good as I used to be, largely as I have less time. But in September and October I become obsessional about migration and wind direction. My best find this year as I write this was a Terek sandpiper in north Northumberland in July and if anyone knows about birds they can make a judgement about where that sits in the rare bird pantheon. I did nine years on the British Birds Rarities Committee (until about 2006 I think) and am now on the British Ornithologists Union Records Committee so every now and again I find myself spending a day debating redpoll taxonomy or puffin wing lengths or something – it is a different planet. I also catch lobsters (about 22 last season – very tasty) and cook seafood and gave a couple of courses last summer. So yes, I keep ticking over.


*A GMC complaint is no reason for immediate panic. Here medical adviser* Mary Peddie *runs through the stages in an investigation*

# Letter from the GMC

OFTEN the first we hear of a GMC complaint is an anguished telephone call from a member to say a letter has arrived from the regulator and they are worried that they will be struck off and crucified in the tabloid press with friends, family and colleagues reading all about what a terrible doctor they are. Whilst it might be understandable to worry, in our experience very few GMC cases make it beyond written correspondence.

The first task as an adviser – after having calmed the member down – is to try to establish the type of letter received. Is it the first notification the doctor has had stating that the GMC will be investigating a complaint – or is it a letter to say that a complaint has been received but it does not require a formal investigation to be opened at that stage?

In either case, the member will need to complete a work details form which should be sent back to the GMC as soon as possible and definitely by the date on the covering letter, usually a week after the date of the notification letter. Details of all medical work should be included, whether paid or unpaid. Normally we advise that no other information or comment should be provided at this stage.

## Careful response

Members are often desperate to tell the GMC their side of the complaint, especially if they have been unaware of any dissatisfaction by the patient, or the family of a deceased patient. Sometimes it may be apparent that the complainant has misinterpreted a situation or has only partial information. It can be difficult to persuade a member that the best course of action is not to fire off a response in the heat of the moment. Anything sent in response at this stage will be copied to the complainant who will then have another opportunity to provide critical comments, or to refute the doctor's explanation.

Sometimes we advise against sending any initial response at all as there is no obligation to do so. This is particularly the case when it is unclear what issues the complainant has with the doctor, or when there are multiple allegations of poor performance or a referral by the doctor's employer or contractor.

The onus is on the GMC to investigate and decide whether the issues raised in a complaint are such that there is a reasonable prospect that a doctor's fitness to practise may be impaired. In some cases, it may not be obvious why a particular doctor is being investigated. In these situations, although it may be tempting to send off detailed comments, in our experience it is unlikely to end the complaint. Furthermore, without a specific issue to focus on, the member runs the risk of saying something which opens up another avenue of investigation for the GMC. It is often better to wait for a further written stage when the GMC will provide more specific allegations, sometimes based on an expert report; these are often easier to answer.

## Send MDDUS all documentation - promptly

Before making any detailed response, we will advise the member to send a copy of ALL of the documentation provided to them by the GMC, along with the covering letter as this gives the case reference and contact details of the GMC's investigation officer. In complex complaints, this documentation may run into several pages (sometimes hundreds) and the quickest way for us to receive the papers is to photocopy the complete bundle and send them by special delivery to our Glasgow office (ensuring that your membership number is included).

Documentation should be sent as soon as possible so we can set up a file and consider the substance of the complaint. We will also ask the member to provide a report on the events giving rise to the complaint, together with their proposed response, a brief summary of their career to date, and copies of the relevant medical records. We will use all this information as the basis for a response to the GMC. It will take time to draft a response and may involve our legal team; hence the need for all relevant documentation to be sent as soon as possible.

On receipt we will write back to the member with our standard letter of agreement (LOA) for signature. An MDDUS case reference will be included on the letter and this should be quoted thereafter when making contact or sending further documentation. We require the signed LOA as confirmation that the member wishes us to assist and that we can liaise with the GMC about the complaint on their behalf.

Any draft response to the GMC will be sent to the member for careful review to ensure not only that you are happy with what has been written on your behalf but also that it is accurate and adequately reflects the sequence of events. Any contradictory details arising later in the case may reflect adversely. There is no compulsory timescale for responding at this initial stage but we usually try to do so within four weeks; hence the reason again for requesting that information is sent to us promptly.

## Expert review

In clinical complaints, the GMC will now invariably seek an expert view from a relevant specialist of the care provided to the patient who is the focus of the complaint. It can sometimes be helpful for the member to provide detailed comments in the response as this will assist the expert when compiling their report. Any personal reflections from the doctor on the care provided can also be helpful, especially if it is a situation where this has been less than adequate in some way. This might also include any remediation, lessons learned and CPD that might help reassure the GMC that there are no ongoing concerns about fitness to practise. The expert report will be provided to the member once available and, if appropriate, further comment can be made.

> "In our experience very few GMC cases make it beyond written correspondence"

The documentation will then be passed to two case examiners, one medical and one lay, who will review the case and decide whether any additional information is required or whether the investigation can be concluded. The vast majority of complaints conclude at this first stage with no further action. Sometimes the doctor will be sent a "letter of advice" to reflect on particular sections of *Good Medical Practice* relevant to the complaint, but no further action is required and no detail of the complaint is recorded on the GMC website.

Cases can also be concluded at this stage with a "warning". This is considered appropriate for less serious departures from *Good Medical Practice* and is not an action against registration. However, it will be published on the GMC website for five years and must be declared in any job application. Whilst it is possible to challenge the proposal to issue a warning, this requires attendance at an Investigation Committee hearing in Manchester.

In complaints not concluded at this stage, there is another written stage in which a letter detailing specific allegations (often based on the conclusions of the expert report) is sent to the doctor. A response must be sent to the GMC within four weeks and our legal department will at this stage be involved in reviewing the correspondence and considering the terms of any response. Normally we will meet with the member in person to consider all the issues in detail before submitting a response.

GMC case examiners will again review the papers and may decide to conclude the case with no further action or a letter of advice, or issue a warning. They may also decide at this stage to refer the member to a fitness to practise panel, or in certain types of case to offer undertakings to be agreed by the member.

Unfortunately, the whole process can sometimes take many months and we recognise that it is very stressful for the doctor involved. The medical adviser (and solicitor) allocated to the file are there to offer support through all of the steps of an investigation, and to the (hopefully) successful conclusion.

■ ***Dr Mary Peddie is a medical adviser at MDDUS***

Allan Gaw *recounts the sulfanilamide tragedy of 1937 and the role of one young research scientist in our modern approach to the approval of new drugs*

# Drugs that will take little lives


OUR approach to the investigation and approval of new drugs is said to be "born in scandal". The scandals in question that gave birth to new drug legislation may be well-known but less often appreciated is the role played by one individual – a rather modest and often unassuming woman called Frances Oldham Kelsey, who died this year aged 101.

Kelsey is best known as the FDA regulator who kept thalidomide out of the US in the 1960s but her first brush with the kind of scandal that would shape the law came in the second year of her doctoral studies in Chicago in 1937.

## An antibacterial elixir

The story began when a small drug company in the state of Tennessee, called Massengill, decided to market the new drug sulfanilamide as an oral liquid preparation. This antibacterial in pill form had been highly effective in combatting bacterial infections in the pre-antibiotic era and Massengill saw a market for it in children with streptococcal throat infections – hence their desire to offer it in liquid form. The problem they faced was that the drug was insoluble in water and quite unpalatable.

The company's chief pharmacist, Harold Watkins, experimented and was pleased to report that he had managed to dissolve the sulfanilamide in an ethanol-like solvent that even tasted sweet. As such, the drug could be sold as an 'elixir', or alcohol solution. However, the solvent was not alcohol but diethylene glycol, the chief constituent of anti-freeze and highly toxic.

Pre-marketing safety testing was neither required by law nor contemplated by the company and the 'elixir' was merely assessed for flavour, appearance and fragrance. After adding some colouring and raspberry flavouring, the company was satisfied on these counts and the preparation was mass-produced, bottled and shipped across the US in September 1937.

## Slow and painful deaths

Reports of the first six suspicious deaths arrived in the American Medical Association's offices as early as October 11 from Oklahoma. The Food and Drug Administration (FDA) was alerted and set about the retrieval of all shipped bottles. Of the 240 gallons that had been distributed, 234 gallons and one pint were recovered. However, the balance had been consumed and had caused the deaths of 107 people, mostly children. Those deaths had been slow and painful; victims would typically be ill for 7-21 days and show features of renal failure, including nausea, vomiting, convulsions and severe pain.

One distraught mother, Maisie Nidiffer, wrote to President Roosevelt himself to describe the death of her six-year old daughter, Joan.

*"All that is left to us is the caring for her little grave. Even the memory of her is mixed with sorrow for we can see her little body tossing to and fro and hear that little voice screaming with pain and it seems as though it would drive me insane. ... It is my plea that you will take steps to prevent such sales of drugs that will take little lives and leave such suffering behind..."*

With her letter, she enclosed a photograph of her now deceased child. Joan Nidiffer's smiling face made its way into numerous newspaper reports about the incident. A face — that of a beautiful little girl — had been given to the tragedy.

## Investigations

Eugene Geiling of the FDA was asked to lead the pharmacological investigations into the sulfanilamide affair. As Geiling's graduate student, Frances Kelsey helped conduct the animal studies to find out which was the toxic agent — the

PHOTOGRAPHS: FDA; SCIENCE PHOTO LIBRARY

From far left: Joan Nidiffer, the six year old killed by the medicine; a bottle of elixir sulfanilamide; Frances Kelsey, seen here in the 1930s helping Dr EMK Geiling; President Roosevelt

"It is my plea that you will take steps to prevent such sales of drugs that will take little lives and leave such suffering behind..."

sulfanilamide or the solvent. Geiling later published these findings showing conclusively that the solvent was the culprit, confirming a number of previous papers. Thus the literature, even in 1937, could have been used to highlight the toxicity of diethylene glycol, but Massengill denied any responsibility.

The company owner, said: "My chemists and I deeply regret the fatal results, but there was no error in the manufacture of the product. We have been supplying a legitimate professional demand and not once could have foreseen the unlooked-for results. I do not feel that there was any responsibility on our part."

While this may have been true from a strictly legal perspective, perhaps not all of Massengill's staff agreed with this abrogation of any moral responsibility. Indeed, the 108th death as a result of the tragedy was the company pharmacist, Harold Watkins, who had first proposed the use of diethylene glycol. He committed suicide in January 1939.

## New regulation

Medicines at the beginning of the 20th century were almost completely unregulated. The 1906 US Pure Food and Drugs Act had established penalties for adulteration and misbranding, but by the 1920s this legislation was increasingly thought unfit for purpose. In the 1930s new legislation had been proposed to strengthen pharmaceutical regulation, but by 1937 this had failed to make it through Congress.

The only legal charge that could be brought against Massengill at the time was one of misbranding. They had labelled their product an 'elixir', but it contained no alcohol. For this they were fined a total of $26,100. If they had called their product a 'preparation' or a 'solution' they would have committed no crime at all, despite the death toll. The powerlessness of the Federal Government to act, other than on the basis of such a trivial matter, was used in the argument to force through tougher legislation to control the future manufacture and sales of drugs.

The US Secretary of Agriculture produced a report on the tragedy. His report included the Nidiffer letter and photo and set out principles that now form the basis of modern pharmaceutical regulation. The report very much framed the sulfanilamide affair as an avoidable tragedy, and one that needed a change in the law to prevent its recurrence. Based on this report, the stalled bill was redrafted, and after some political horse-trading it was passed and Roosevelt signed it into law in 1938, eight months after the first 'elixir' deaths.

The resulting Food Drug and Cosmetics Act of 1938 has been described as "one of the most important regulatory statutes in American and perhaps global history." It created a new legal category: the 'new drug' and authorised the FDA to serve as gatekeepers for such compounds entering the market place. Thus, the FDA acquired greater status and considerably sharper teeth, with pharmaceutical companies now compelled to work in a new landscape of greater scrutiny and transparency.

Kelsey's involvement in the 1938 legislative reform was obviously peripheral, but she was at the centre of the laboratory work that confirmed the toxicity of the 'elixir'. Twenty-five years later Kelsey recalled: "The urgency of the situation, the intensive round-the-clock toxicologic studies and the subsequent changes in the law relative to the control of drugs could not, and did not, fail to make a deep impression on a graduate student such as myself".

The legislative journey that began in the US in 1938 would not end there. Throughout the 20th and into the 21st centuries this law which strives to create an environment that puts patient and public safety at the forefront would be amended many times.

One of the most important legislative changes still to come would be in 1962 in the marketing of a new drug to treat nausea in pregnant women – and this time Frances Kelsey would play the starring role.*

■ ***Dr Allan Gaw is a clinical researcher and writer in Glasgow***

** Go to Publications at **mddus.com** to read more about Frances Kelsey and the thalidomide scandal in the Summons Winter 2014 issue*

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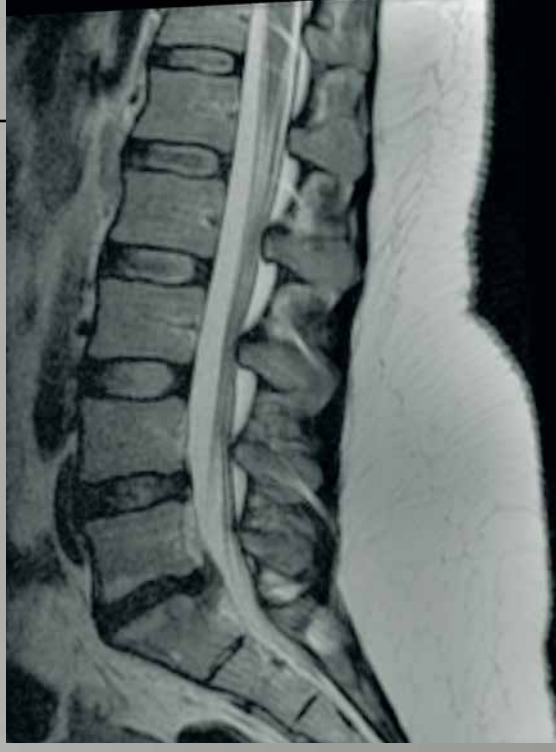


# Cauda equina syndrome

*Consultant neurosurgeon* Robert Macfarlane *highlights the need for early diagnosis and treatment to avoid irreversible nerve damage in cauda equina syndrome*

THE diagnosis and management of cauda equina syndrome (CES) can be fraught with potential difficulties. Back pain and sciatica are common conditions, but an average GP will probably encounter only one or two cases of CES in their professional lifetime.

A patient in pain from a disc prolapse may have difficulty passing urine purely for mechanical reasons. The analgesics used in treatment almost invariably cause constipation. This situation is entirely different from CES where, instead of a lumbar disc protruding to one or other side of the spinal canal and compressing nerve roots to the lower limbs, it prolapses centrally. Here it impinges on the nerves subserving sensation to the saddle region, bladder, urethra and rectum, as well as the parasympathetic motor innervation to the bowel and bladder.

It is critical to diagnose CES at an early stage because these nerves have characteristics which make them both vulnerable to injury and unlikely to recover from a severe insult. Firstly, they comprise small myelinated and unmyelinated nerves which are less resilient to compression than larger fibres. Secondly, because compression occurs proximal to the cell body, axons will not regenerate if Wallerian degeneration develops.

CES may be subdivided into two categories. At first there is impairment of bladder/saddle sensation and difficulty with micturition, but the patient remains continent (CESI – an incomplete lesion). The syndrome becomes complete when the bladder is no longer under voluntary control and the patient has painless urinary retention with dribbling overflow incontinence (CESR). At the outset the patient will be constipated through loss of the parasympathetic innervation to the descending colon, even although anal tone may be lax. Faecal incontinence is generally a very late sign in CES and its absence should not be regarded as reassuring.

Although there remains controversy regarding management of CESR, many studies have concluded that, once this state is reached, the opportunity has been lost to reverse the situation by emergency decompression. In contrast, the outcome for CESI is usually favourable; therefore it is important to achieve decompression before the patient has progressed to CESR. Any perceived delay in diagnosis and treatment, or failure to warn the patient of the need to seek urgent attention should CES symptoms develop, may lead to allegations of negligence.

## Differentiating CESI

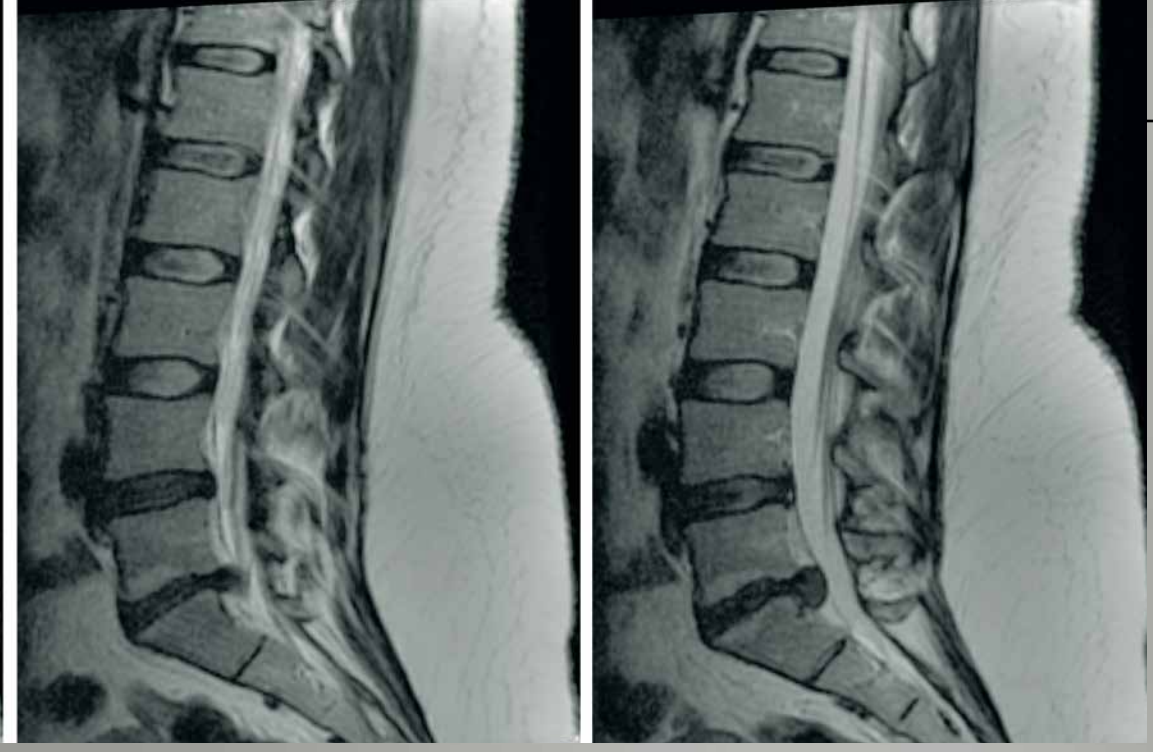
A detailed history is needed to differentiate between CESI and bladder disturbance secondary to pain and constipation. The patient in pain who is having difficulty voiding purely for mechanical reasons is aware that the bladder is full, retains the desire to micturate, has normal sensation in the saddle region, and a tender bladder. Urethral sensation is preserved and the patient can differentiate flatus from faeces. In contrast, the patient developing CES will experience some or all of the following:

- altered saddle and/or urinary sensation
- perineal/rectal pain
- reduced awareness of bladder filling
- the need to strain to maintain urine flow.

On abdominal palpation the bladder may be distended but not tender. Saddle sensation may be reduced to light touch and/or pinprick. In the early stages, anal tone will remain normal.

Unfortunately, the distinction between the two is not always clear. Some patients will complain of altered saddle sensation but an MRI will show no compression. Conversely, a person with CESR may remain continent by toileting regularly to avoid over-distension of the bladder, and micturate by straining or applying lower abdominal pressure. Although the presence of bilateral sciatica is well-known as a 'red flag' for CES, many cases will only ever have unilateral sciatica. Very occasionally, an L5/S1 central disc may compress the cauda equina without involving the laterally-placed nerve roots. CES can therefore occur without sciatica. Neither is report of an improvement in back pain/sciatica always reassuring. When the disc fragment migrates centrally, pressure may be relieved from the laterally-placed nerve roots. This results in relief of sciatica at the time that CES occurs. If doubt exists about the diagnosis, the only way in which this can be resolved is by emergency MRI.

PHOTOGRAPHS: SCIENCE PHOTO LIBRARY



"If doubt exists about the diagnosis, the only way this can be resolved is by emergency MRI"

## Medicolegal aspects

In the context of general practice and accident & emergency, the areas most likely to cause difficulty are, firstly, failure to consider the diagnosis of CES. Secondly, patients may dispute the accuracy of their records, alleging that CES symptoms were present at an earlier date but were not recorded accurately or acted upon. Thirdly, patients may accept that they did not have symptoms of CES at the time of a particular consultation but allege that they should have been given 'red flag' warnings about the early symptoms and told to seek emergency medical attention should they occur. Fourthly, there may be a delay in seeking specialist opinion.

There are two particular additional hazards in hospital care. The first is in failing to arrange investigation of suspected CES with appropriate urgency, particularly in units that do not operate an out-of-hours MRI service. The second is the timing of surgery once the diagnosis has been established. The degree of urgency with which CESI should be investigated will depend upon the clinical circumstances. In nearly all cases MRI is required as an emergency because of the risk that they may progress to CESR with any delay. If it is not possible to arrange this out of hours then the patient should be transferred elsewhere. On rare occasions where a history of early CES has been obtained but symptoms have been static for some days, it may be acceptable to delay investigation overnight, provided the patient is warned to report any deterioration. Measurement of urinary volumes and post-void residuals may be reassuring.

Whilst some clinicians have interpreted the outcome of a meta-analysis by Ahn et al (2000) as indicating that there is a 48-hour 'window' in which to treat CES, this notion is unsafe (Chau et al, 2014). In particular, it does not apply to CESI. Once the diagnosis has been made, CESI will usually be treated as a surgical emergency, regardless of the hour. However, this decision is not always straightforward. Surgery for a large central disc can be challenging and carries a risk of adding to the deficit if performed under less than ideal circumstances. It may be argued, therefore, that it is appropriate to delay decompression by a few hours if, by doing so, the risk will be lessened.

As far as surgery for CESR is concerned, meta-analysis suggests that there may still be merit from emergency decompression (Todd, 2005). However, much of the literature suggests that outcome is no better, and that decompression can be delayed until the first case the following day. In the interim, the patient should be catheterised to avoid bladder over-distension leading to secondary detrusor failure.

## Minimising the risk

A number of measures can be taken to minimise the risk of litigation, although they should not all be seen to represent a standard of care:

- Think about the diagnosis of CES in every patient with back pain and sciatica. Make a written note if there is no evidence of this condition.
- Warn the patient to seek emergency attention if they develop CES symptoms. Document that they have been told this.
- If CES is suspected, telephone the on-call orthopaedic or neurosurgery team. Do not be reassured if a junior doctor tells you to refer the patient as an urgent out-patient. If you are not satisfied with the response, seek a more senior opinion or tell the patient to attend A&E.
- Lack of an emergency MRI service is not a valid reason to delay investigation. If the degree of clinical urgency cannot be met, refer the patient elsewhere.
- CESI is usually treated as a surgical emergency, regardless of the time of day. If there are good clinical reasons to delay decompression, document why this is justified. If the delay is due to lack of surgical expertise, consider referring the patient elsewhere.

■ *Mr Robert Macfarlane is a consultant neurosurgeon at Addenbrooke's Hospital, Cambridge, and also provides expert reports for MDDUS*

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# Keeping kids out of the

Colwyn Jones *looks at the success behind the much-lauded Childsmile programme which has led to a demonstrable improvement in the oral health of children in Scotland*

CHILD dental health in Scotland has seen a significant improvement which started before devolution in 1999.

In 1994 only 38 per cent of primary 1 children were dentally healthy, that is free from obvious deciduous tooth decay. By 2014 this had risen to 68 per cent. For children aged about 11 years in primary 7, those free from decay in the permanent dentition rose from 52.9 per cent in 2005 to 72.8 per cent by 2013. This is typically credited to a national population-based initiative called Childsmile.

## Art and science

Childsmile has a long history and is an excellent example of effective public health knowledge put into action. Dental public health has been defined as: "The science and the art of preventing oral disease, promoting oral health and improving the quality of life through the organised efforts of society". By these criteria Childsmile can be judged a success: the science being the solid evidence-base behind the programme and the art being the incremental development of Childsmile through the political process, working both nationally and locally with education departments in local authorities.

It developed largely from two national demonstration programmes run between 2006 and 2008, which had been in the government *Action Plan for Modernising Dental Services in Scotland*, published in 2005. However, this action plan resulted from a 2002 consultation: *Towards Better Oral Health in Children – A Consultation Document on Children's Oral Health in Scotland*.

Childsmile is funded by the Scottish Government and has four main elements which, when combined, provide a comprehensive pathway of dental care that is tailored to the needs of individual children: Childsmile Core, Childsmile Practice, Childsmile Nursery and Childsmile School. Since 2011 all four elements have been delivered in all health boards throughout Scotland, but the early development of these was incremental.

## Childsmile Core

The consistent finding before the mid-1990s was that tooth decay could be found in almost two-thirds of primary 1 children in Scotland. Decay in deciduous teeth can take up to two years to develop, so to have a preventive effect, fluoride needs to reach the surface of these teeth before children are three years of age.

The Childsmile Core programme aims to provide topical fluoride to the teeth of every child in Scotland. It is available throughout the country, and every child (currently about 60,000 are born each year) is provided with a dental pack containing a toothbrush and a tube of fluoride toothpaste on at least six occasions by the age of five years.

In addition, every three and four-year-old child attending nursery (whether local authority, voluntary or private) is also offered free, daily, supervised

# dental chair

toothbrushing. This comprehensive approach involving every child is one of the main reasons that Childsmile has been so successful. For children already brushing twice a day at home the benefit may be marginal but for those who do not brush regularly the preventive effect is huge.[1] Healthy snacks and drinks are also an important part of the programme.

## Childsmile Practice

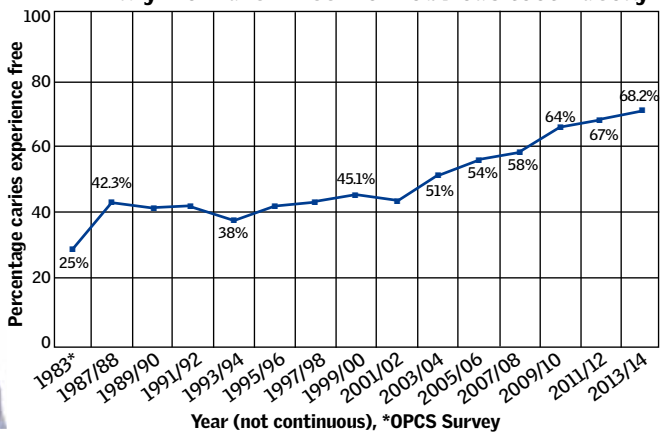
Childsmile Practice was successfully piloted among health boards in West of Scotland between 2006 and 2008. However, since October 2011 it has been integrated into the Scottish Statement of Dental Remuneration (SDR) and all practices delivering NHS care to children are expected to deliver Childsmile interventions.

Dietary advice that fosters good oral health behaviour – including information on nutrition and drinks (to prevent decay) – must be realistic and achievable. When it comes to toothbrushing, Childsmile highlights when to brush, the types of brushes and toothpaste to use, the amount of toothpaste, and methods and demonstrations where parents brush their child's teeth to foster skill acquisition. The programme also provides fluoride varnish applications in all children over two years of age, twice a year. This is all in addition to routine dental check-ups.

The Childsmile Practice programme is designed to improve the oral health of children in Scotland from birth by working closely with dental practices. It is a universally accessible child-centred NHS dental service using a network of primary care dental service providers, both independent contractors and public dental services. Families are referred by a health visitor to a dental practice or to a dental health support worker (DHSW).

The DHSW will contact the family of children from the age of three months to make a first appointment for the child with a local Childsmile dentist and provide a link between dentists, the family and the health visitor. If required the DHSWs give additional dental health support to children and families most in need and try to get children who have been identified as not currently attending, to visit a dentist. Additional support is given to children and families most in need through home visits, community initiatives and primary care dental services.

**30 year trend in the percentage of Scottish Primary 1 children free from obvious tooth decay**




## Childsmile Nursery and School

Childsmile Nursery and Childsmile School were mainly piloted in East of Scotland health boards. The core programme includes universal toothbrushing in all nursery establishments. This is enhanced by targeting fluoride varnish applications to regions with the highest levels of socio-economic deprivation, which are the areas in Scotland where regular dental surveys have shown more children have tooth decay. Extended duty dental nurses (EDDNs) work in health boards or independent practices and provide preventive advice and regular fluoride varnish applications.

Childsmile School targets primary schools in areas with the highest levels of socio-economic deprivation and tooth decay among children. There is also daily supervised toothbrushing in primary 1 and 2 classes and regular fluoride varnish applications.

## Tackling health inequalities

Childsmile follows what Geoffrey Rose called a population or universal preventive approach. There is no evidence to suggest that it has widened dental health inequalities, quite the opposite. This universal or structural approach to prevention, which does not rely on individual behaviour change, is one key lesson from the success of the Childsmile programme. The second lesson is very much simpler: the programme is properly funded.

Childsmile has succeeded but there is still a lot to do as one-third of five-year-old children still suffer tooth decay, even if less severe. This is a painful, miserable problem which can be entirely prevented. Childsmile has successfully evolved since it started and this learning approach involving all staff means the programme will continue to build, tweak and change a successful preventive formula for the benefit of the Scottish population.

What about the rest of the UK? The best advice to other countries is to first get universal nursery toothbrushing with fluoride toothpaste in place.

■ ***Dr Colwyn Jones is a consultant in dental public health and Head of the Evidence for Action Team at NHS Health Scotland***

1 Evidence supporting this approach can be found in *The Cochrane Review: "Fluoride toothpastes for preventing dental caries in children and adolescents provides the evidence that supports the core programme"* (Marinho VCC, Higgins JPT, Sheiham A & Logan S, 2013)

# CASE studies

These studies are based on actual cases from MDDUS files and are published in *Summons* to highlight common pitfalls and encourage proactive risk management and best practice. Details have been changed to maintain confidentiality

## TREATMENT: LONG-TERM NEGLECT?

**BACKGROUND:** MR B, 32, attends his dentist as a new patient. His teeth are in poor condition and it would appear he has neglected to clean them regularly. His dentist, Mr H, carries out a root canal treatment and advises him to brush at least twice a day and to floss regularly, scheduling a follow-up appointment for six months' time. Mr B fails to show and attends at the practice 18 months later as an emergency, complaining of bleeding gums. Mr H again advises on good oral hygiene and prescribes an appropriate mouthwash for the infection. A six-month review is booked but Mr B again fails to show.

Over the next three years, Mr B attends sporadically and each time the dentist offers advice on good hygiene and explains this is crucial to keep his gums healthy. Radiographs are taken, confirming his teeth are in poor condition and on three occasions (over three years) the patient undergoes extensive scaling. Following each scaling, a six-month review appointment is set but Mr B fails to attend any of them. Mr H also carries out a number of restorations to various teeth during this period.

Mr B attends for another appointment, almost five years since his initial consultation, where his teeth appear to have worsened due to lack of brushing. They are cleaned extensively and Mr H again emphasises the need to brush and floss regularly. He sets a six-month review appointment but Mr B cancels and does not return to the practice.

Six months later, Mr H receives a letter of claim from solicitors acting on behalf of Mr B alleging clinical negligence. It is claimed Mr H failed to diagnose or treat the patient's periodontal disease, failed to carry out basic periodontal examinations, or to offer sufficient oral health advice, and failed to refer him to a hygienist or specialist periodontist.

It is alleged this caused Mr B considerable pain and suffering. It transpires that Mr B has seen another dentist who informed him he has periodontal disease and now requires ongoing periodontal care and possible orthodontic treatment

**ANALYSIS/OUTCOME:** MDDUS, on behalf of Mr H, disputes the allegations. It is argued that Mr B must bear some responsibility due to his consistently poor oral hygiene and his failure to attend to complete scheduled treatment.

MDDUS commissions a report from a dental expert and she is largely supportive of Mr H's decision-making. In particular, she agrees with his decision not to make a periodontal referral for Mr B as such treatment would only succeed in patients who can demonstrate a continued good level of oral hygiene. This could not be established in Mr B's case due to frequent non-attendance. The expert also agrees that Mr H's notes suggest he frequently offered oral hygiene advice but Mr B failed to follow it.

Mr B's solicitors do eventually concede that the patient must bear some of the blame, but they insist Mr H was negligent.

One major failing is identified, however, in that Mr H appears not to have begun carrying out BPEs until around two years after his patient first attended. In addition, a review of his BPE charting suggests Mr H may not have noted it accurately. This is confirmed when a comparison is made between BPEs carried out by Mr H and those of a second dentist, and a periodontist five weeks later. Mr H's scores vary wildly from the other two.

Due to the delay in commencing periodontal monitoring and the apparent inaccuracy of his scoring, it is agreed – in consultation with the member – to settle the case for a moderate sum.

**KEY POINTS**

- All new patients should have a basic periodontal examination recorded and appropriate follow-up care arranged.
- Ensure accuracy of BPE recording and familiarise yourself with the latest guidance from the British Society of Periodontology.
- Patients who fail to follow oral health advice must bear some responsibility for poor dentition but this does not always excuse the treating dentist.

# DIAGNOSIS: SHOOTING PAINS

**BACKGROUND:** A 51-year-old woman – Ms T – attends her local surgery complaining of ongoing pain in her back and legs.

A year previous she had injured her neck in a skiing accident and had undergone surgery to treat spinal cord compression. Recently at a neurosurgical outpatient clinic she had complained of shooting pains in both legs and difficulty walking and is now on a waiting list for an MRI assessment of her spine.

A GP – Dr L – takes a detailed history and examines the patient and finds no abnormality of sensation or power in the legs and no tenderness over the lumbar spine. The diagnosis is sciatica and she notes the letter from the neurosurgeon regarding the imminent MRI assessment. Ms T is prescribed ibuprofen and referred for physiotherapy. The management plan concludes: "Review if not better".

The physiotherapy brings no improvement and three weeks later Dr L notes a telephone request for pain relief due to "recurrence of backache". More ibuprofen along with co-codamol is prescribed. Two days later Ms T again phones the surgery and this time requests a home visit. Dr L returns her call and records that the patient complains of severe back pain radiating down both legs to her knees with muscle cramps in her calves and difficulty walking. The patient reports that she is not suffering incontinence or numbness in her legs. The GP prescribes co-codamol plus diazepam but the next day Ms T phones again to say the pain is so intense she cannot make it to the bathroom.

Dr L visits the patient at home and notes severe back and leg pain, especially on straight-leg raises, but again normal sensation and muscle power on examination. She advises continued analgesia.

Two days later Ms T phones a local out-of-hours service. A GP attends her at home and notes that the patient has developed some numbness in the saddle area and cold feet in addition to low back pain shooting to the ankles, cramps in the calves and hip pains. His diagnosis is possible prolapse of a lumbar intervertebral disc. He phones the local hospital and arranges for urgent admission to the orthopaedic unit. Here further examination reveals reduced sensation over the outer aspect of the left leg and foot, absent ankle tendon reflexes and some urinary incontinence.

Later imaging of the spine shows prolapse of the intervertebral disc between the fourth and fifth lumbar vertebrae, confirming a diagnosis of cauda equina syndrome. Emergency surgery is performed that evening. Ms T's pain is relieved but she suffers complications with residual impairment of sensation and muscle power in the lower limbs, along with impaired bladder and bowel function. She is forced to give up her job as a teaching support assistant at a local primary school.

Five months later Dr L receives a letter from solicitors acting on behalf of Ms T claiming clinical negligence in the management of her condition. It is alleged that the GP failed to act properly on severe bilateral leg pain present for at least 10 weeks. It is stated that the nature, duration and recent increased severity of the pain would have led any competent general practitioner to carry out a detailed examination, including sensation testing in the legs and saddle regions. In doing so the GP would have detected sensory disturbance and referred the patient for urgent assessment.

**ANALYSIS/OUTCOME:** MDDUS acting on behalf of Dr L commissions expert reports from a primary care physician and a consultant neurosurgeon. Both confirm that back pain radiating down both legs does not necessarily signal nerve root compression but may also be musculoskeletal. Crucial "alarm symptoms" for cauda equina syndrome comprise sensory loss involving the "saddle area" of the perineum between the legs and also reduced sensation of bladder and bowel filling along with incontinence.

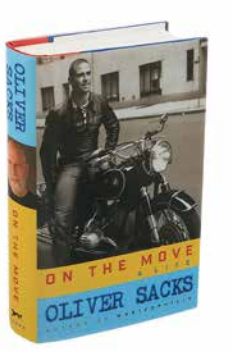
In her assessment of Ms T both via phone and in person the GP noted that the patient reported no incontinence or loss of sensation, and no other definite signs of incipient or present cauda equina were noted.

Both experts agree that Dr L would have had no call to arrange an urgent referral or seek specialist advice prior to the patient's later admission to hospital. MDDUS solicitors repudiate the claims against Dr L in a letter of response and the case against the GP is eventually discontinued.

**KEY POINTS**

- Record both positive and relevant negative findings on clinical examinations.
- In stating a diagnosis, justify how conclusions are reached and state any uncertainties or differentials.
- Consider pre-existing conditions but beware of possible unrelated causes.

# Book review:
## On the move




By Oliver Sacks
Picador, £20.00 hardback
Review by Dr Greg Dollman, medical adviser, MDDUS

**OLIVER** Sacks' memoir, *On the move*, recalls his "lucky" life as an adventure and a journey of discovery. The professor of neurology and author of numerous international bestsellers, including *Awakenings* and *The man who mistook his wife for a hat*, chose and explored intently the road less travelled. He died shortly after publication of this book at age 82.

Sacks seemed to push all the boundaries and break all the stereotypes. He was a bundle of contradictions. The photograph on the dust jacket of this autobiography pricks the intrigue: posing on his BMW R60 motorcycle in leather jacket, he could be James Dean or Marlon Brando. Sacks rode alongside the Hell's Angels, was a record-breaking weightlifter and a hardened user of street drugs. He was also an exceptional piano player, a fan of *Star Trek* and enamoured with ferns. He was notoriously clumsy: nicknamed Inky as a boy owing to his messiness, he lost several manuscripts, dropped food crumbs onto histopathology slides, and had innumerable personal accidents. Nevertheless, he was a meticulous recorder of detail, his personal journals were voluminous.

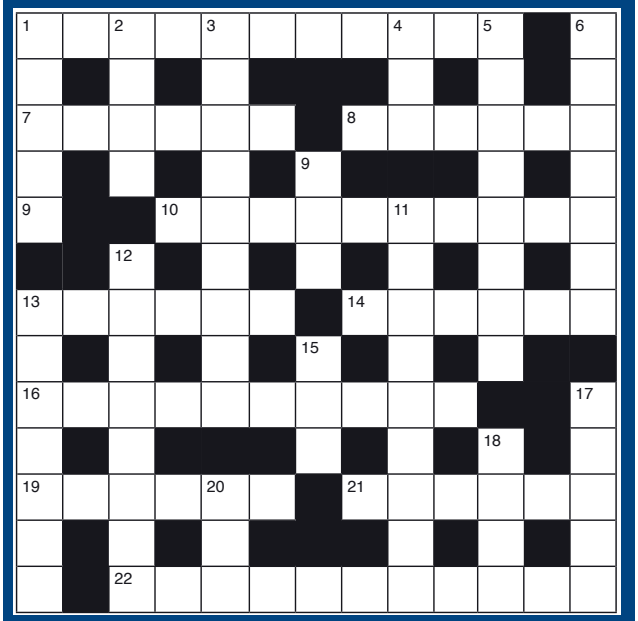
Those who have read Sacks before will appreciate his gift for unravelling the interplay of life and medicine. No doubt this stemmed in part from his personal experiences. He tells of growing up in a family of doctors, the bond with his brother diagnosed with schizophrenia, his own ocular melanoma and even facial blindness (which he so eloquently described in others in his case studies).

Critics of Sacks argue that he acted irresponsibly when writing about patients. They believe that his works were anecdotal, rather than supported by the rigour of scientific research, and that he abused his position of trust by putting his clinical notes into print. Sacks recognised the power of the case report; his use of this traditional record of medical uncertainty arguably gave impetus to the subsequent research into the conditions he described. He explains that most of his patients encouraged him to write about their conditions, and he carefully documented consent and sought ethics approval for his studies.

In *On the move*, Sacks describes his "excesses", and wonders how he lived past age 35. Was his risky behaviour, and his relentless weightlifting, an attempt to compensate for the "timid, diffident, insecure, submissive" person he considered himself to be? Was it his drug-fuelled experiences that gave him a glimpse into the seemingly-indecipherable minds he investigated? Did his patients recognise Sacks' inner demons, so strengthening the bond they shared? His memoir poses many questions with not all of them answered. He explains that the purpose of his written case studies was not to provide a diagnosis, rather to illuminate that which befitted description.

What is certain is that Sacks' own life story is as eloquently written as any of his case studies.

## Crossword



**ACROSS**
**1** 50-50 (4-3-4)
**7** Famous Frances _____ in 20 Down (6)
**8** Other half (6)
**10** Graph of heart activity (10)
**13** System based on the metre as unit of length (6)
**14** Type of dagger (6)
**16** Plaintiff in recent landmark medical consent case (10)
**19** Eats hurriedly (5)
**21** Artificial opiate (6)
**22** Ostentation (11)

**DOWN**
**1** Out-and-out nonsense (5)
**2** Soothe (4)
**3** Meeting the mean (9)
**4** Snake (3)
**5** Toothpaste additive (8)
**6** Pertaining to heat (7)
**9** Deficit disorder (Abbr.) (3)
**11** Description of the ear (9)
**12** Impasse (8)
**13** Imitation, Greek orig. (7)
**15** Flightless bird (3)
**17** Avoid car (5)
**18** Localised thickening of skin due to pressure (4)
**20** US regulatory body (Abbr.) (3)

See answers online at:
**http://www.mddus.com/news/notice-board/**

# Object obscura:
## Radioactive soda water


PHOTOGRAPH: SCIENCE PHOTO LIBRARY

**THIS** box contains vials of an early 20th century preparation of radium, designed to be used with a siphon to prepare radioactive soda water. Radiation was once considered the ultimate health cure before being recognised as highly toxic and carcinogenic. The directions for use say: "One tumblerful to be taken twice daily after the principal meals." *Source:* Science Photo Library

# Vignette: pioneering pathologist Dorothy Stuart Russell (1895-1983)

KNOWN as "the lady", Dorothy Russell broke ground in many areas – not least as the first woman in Western Europe to occupy a medical chair of pathology. As a scientist, her achievements were significant and of practical importance: for example, she showed how new brain smear techniques could be used for diagnosis during a brain operation. She was also one of the first pathologists to grow tumour cells in culture (e.g. astrocytoma) which was important in showing the origin of meningiomas.

Dorothy was born in Sydney, Australia. Her father died when she was three and her mother remarried but died two years later. Dorothy and her sister were sent to live with her mother's sister and clerical husband near Cambridge. Despite this early family tragedy Dorothy emerged from Perse school as a self-confident young woman. Her academic excellence and character won her a place at Girton College, Cambridge. After a first in zoology she spent 1918-19 studying medical entomology on a Gilchrist scholarship. She had long wanted to be a medical scientist and her ambition coincided with Government policy that encouraged women to become doctors to replace the dreadful losses of the war years.

Dorothy entered the London Hospital Medical College in 1919 and qualified in 1923. She won the Sutton Prize in Pathology and the Clinical Obstetrics and Gynaecology Prize. She also had sufficient toughness to counter the considerable prejudice against women doctors and the reluctance of the University of Cambridge to award degrees to women. It was not until 1942 that she received her BA from the university.

An important influence on Dorothy's career was the pathologist Professor HM Turnbull, chair of morbid anatomy at the London. Under him she studied renal disease. She published a paper on Bright's disease, which was the basis of her MD thesis. She then joined the Medical Research Council as a staff member, where an Australian neurosurgeon Hugh Cairns was working. He sparked an interest in neuropathology which Dorothy was to follow for the rest of her career. A Rockefeller Scholarship enabled her to work with FB Mallory in Boston then Wilder Penfield in Montreal. She retained her MRC position until 1939.

PHOTOGRAPH: COURTESY OF THE ROYAL LONDON HOSPITAL ARCHIVES & MUSEUM

During the war she worked as a civilian in a neurosurgical unit in Oxford commanded by Cairns, now a brigadier. At the University she experimented with new techniques of staining with metallic impregnations, and the use of antiseptics (such as sulphonamides and the newly discovered penicillin) on the brain. She also studied the effect on the brain of acrylic resin used in surgical closure of the skull. Her scientific work in Oxford was significant.

Cairns wished her to remain in his department but she had other ambitions and returned to London to work for Turnbull and replaced him as Professor in 1946 and as head of the Bernard Baron Institute of Pathology.

She had begun work on the pathology of hydrocephalus in Oxford and this was published in 1949 by the MRC – *Special Report 265: Observations on the Pathology of Hydrocephalus*. In it she cut away jargon like 'idiopathic' and rejected nebulous theories and wrote: 'As far as possible the facts have been allowed to speak for themselves and the theories have been allowed to drop into the background... the immense variety of pathological lesions have this single feature in common: all create an obstruction in some point in the pathway of the cerebrospinal fluid.'

Later she wrote a classic book with a pupil LJ Rubinstein, *Pathology of Tumours of the Nervous System*, which was published in 1959. The beauty of the book was that it simplified Barclay and Cushing's classification of brain tumours, particularly gliomas, and served as a valuable guide for clinicians.

Dorothy took great interest in her students and was an active supporter of their careers: at least a dozen of her pupils or junior staff became professors. Among the awards she received were the John Hunter medal and Triennial Prize of the Royal College of Surgeons in 1934, and the Oliver-Sharpey prize of the Royal College of Physicians in 1968. She was also a fellow of the Royal College of Pathologists.

Dorothy was a very private person; probably few people knew that she suffered from epilepsy. She retired in 1960 to Westcott near Dorking in Surrey where she enjoyed gardening and music. She was also an early supporter of Amnesty.

■ *Julia Merrick is a freelance writer and editor*

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